

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 3 mo.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. STREET ADDRESS R.D.			
3. NAME OF DECEASED (Type or print) First Middle Last MARIE C BLAKER				4. DATE OF DEATH September 23, 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH April 8, 1892	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY Seamstress		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Thomas Conway				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 179-01-4634		17. INFORMANT Clara McFadden	
				Address Elkton, Md. R.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 DUE TO RAVCINOMATOSIS (Origin leukemia) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 3 mos
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from May 1958, to 7/23, 1958, that I last saw the deceased alive on 7/22/58, 1958, and that death occurred at 2:15 A.M., from the causes and on the date stated above.							
ACTUAL SIGNATURE George J. Kreis, Jr. M.D.				ADDRESS (Street, city or town, state) Elkton, Md.			
PHYSICIAN'S NAME (Type) George J. Kreis, Jr.				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/58		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cherry Hill, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE OCT 1 '58	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

10076

10097

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 2814 Maryland Avenue	
3. NAME OF DECEASED (Type or print) First MICHAEL Middle (NMI) Last BRENISH		4. DATE OF DEATH Month September Day 10 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-9-11
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Pharmacist in	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Service (Army) Michael Brenish		14. MOTHER'S MAIDEN NAME Mary Wandison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 15 , 19 42 , to September 10, 1958 , that I last saw the deceased alive on September 10, 1958 , and that death occurred at 12:25 a.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. M. HARRIS		ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md.	
PHYSICIAN'S NAME (Type) W. M. HARRIS		DATE SIGNED 9-12-58	
22a. BURIAL, CREMATION, (REMOVAL) (Specify) 9/12/58		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY unknown		22d. LOCATION (City, town, or county) (State) Philadelphia Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Bennington & Sons		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE SEP 16 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kinas	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

and

RECEIVED
JAN 11 1904
BALTIMORE

Blank certificate form with various fields for recording death information, including name, age, sex, date, and cause of death. The form is oriented horizontally but contains vertical text on the right side.

RECEIVED
JAN 11 1904
BALTIMORE

10098

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 13yrs.5mo.27days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 3907 Pinewood Avenue			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First JOHN Middle R. Last BROWN		4. DATE OF DEATH		Month September Day 8 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-21-1897	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Operator		10b. KIND OF BUSINESS OR INDUSTRY Loom - Meadow Mills		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Lee Brown				14. MOTHER'S MAIDEN NAME Anna Mary Steigerwald			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I		17. INFORMANT Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized, advanced 350x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Parkinsons disease DUE TO (c) unknown				INTERVAL BETWEEN ONSET AND DEATH unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 12 , 19 45 , to September 8 , 19 58 , and that death occurred at 11:10 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 9-9-58 ACTUAL SIGNATURE S. P. LACERVA M.D. PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-11-1958		22c. NAME OF CEMETERY OR CREMATORY Parkwood		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lassahn Funeral Home, 7401 Belair Rd., Baltimore, Md.				24a. REC'D BY REGISTRAR SEP 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10078

10083

Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>1 mo 28</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton, R.D.4.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Union Hospital</u>			d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>D.</u> Middle Last <u>Carter</u>			4. DATE OF DEATH Month <u>9</u> Day <u>14</u> Year <u>19 58</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> Separated	8. DATE OF BIRTH <u>9-22-1877</u>		9. AGE (In years last birthday) <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Johnnetta Carter</u>			14. MOTHER'S MAIDEN NAME <u>Mary Ellen Chedister</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>221-03-8573</u>		17. INFORMANT Address <u>Beulah Powell, Claymont, Del.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u> <u>9040</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture of left femur</u> (a), stating the underlying cause last. DUE TO (c) <u>Arteriosclerosis</u>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>491X</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in his home</u>			
20c. TIME OF INJURY <u>2:55</u> a.m. <u>7 17</u> p.m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Elkton</u>	(County) <u>Cecil</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>R. C. Dodson</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/17/1958</u>		22c. NAME OF CEMETERY, OR CREMATORY <u>Cherry Hill Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Cherry Hill</u>		(State) <u>Md</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter du Boe Jr.</u>			ADDRESS <u>Elkton Md</u>		
24a. REC'D BY REGISTRAR <u>SEP 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

OR STATE
ATTEST

DEPT OF STATE
ACCIDENT

NATION

DATE WHEN EXAMINED

PLACE WHEN EXAMINED

NAME OF DECEASED

AGE

SEX

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

EDUCATION

OCCUPATION

RELATIONSHIP TO DECEASED

UNUSABLE COPY - VALUE

NOTARY
PUBLIC
STATE OF

DATE

PLACE

SIGNATURE

NOTARY

STATE OF

DATE

PLACE

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10084

10079

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b All life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital			d. STREET ADDRESS 7 Norman Allen St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) EMERSON LANE CROTHERS			4. DATE OF DEATH Month September Day 28 Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 29, 1919		9. AGE (In years last birthday) 39 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Clerk		10b. KIND OF BUSINESS OR INDUSTRY Government		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Emerson Ralph Crothers		
14. MOTHER'S MAIDEN NAME Maude Hague			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes World War II		
16. SOCIAL SECURITY NO. 220-14-6793			17. INFORMANT Lorrayne H. Crothers, Address 7 Norman Allen St. Elkton, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis due to Rupture of Peptic Ulcer 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocardial Infarct due to Arteriosclerotic Cardiovascular Disease					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Partial	
20f. (City or town) Elkton		20g. (County) Cecil		20h. (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William V. Lovitt, Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/29/58	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/1/58		22c. NAME OF CEMETERY OR CREMATORY Gilpin Manor Park	
22d. LOCATION (City, town, or county) Elkton, Md.		22e. (State) Md.		22f. (County) Cecil	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE OCT 1 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Frank					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		SIGNATURE OF EXAMINER		DATE	
LOCALITY		CITY		COUNTY		STATE		FEDERAL BUREAU OF INVESTIGATION		U.S. DEPARTMENT OF JUSTICE	
EDUCATION		RELIGION		MARRIAGE		CHILDREN		SIBLINGS		PARENTS	
MOTHER		FATHER		GRANDFATHER		GRANDMOTHER		BROTHERS		SISTERS	
MOTHER'S MARRIAGE		FATHER'S MARRIAGE		GRANDFATHER'S MARRIAGE		GRANDMOTHER'S MARRIAGE		BROTHERS' MARRIAGE		SISTERS' MARRIAGE	
MOTHER'S BIRTH		FATHER'S BIRTH		GRANDFATHER'S BIRTH		GRANDMOTHER'S BIRTH		BROTHERS' BIRTH		SISTERS' BIRTH	
MOTHER'S DEATH		FATHER'S DEATH		GRANDFATHER'S DEATH		GRANDMOTHER'S DEATH		BROTHERS' DEATH		SISTERS' DEATH	
MOTHER'S CAUSE OF DEATH		FATHER'S CAUSE OF DEATH		GRANDFATHER'S CAUSE OF DEATH		GRANDMOTHER'S CAUSE OF DEATH		BROTHERS' CAUSE OF DEATH		SISTERS' CAUSE OF DEATH	
MOTHER'S MANNER OF DEATH		FATHER'S MANNER OF DEATH		GRANDFATHER'S MANNER OF DEATH		GRANDMOTHER'S MANNER OF DEATH		BROTHERS' MANNER OF DEATH		SISTERS' MANNER OF DEATH	
MOTHER'S RESIDENCE		FATHER'S RESIDENCE		GRANDFATHER'S RESIDENCE		GRANDMOTHER'S RESIDENCE		BROTHERS' RESIDENCE		SISTERS' RESIDENCE	
MOTHER'S OCCUPATION		FATHER'S OCCUPATION		GRANDFATHER'S OCCUPATION		GRANDMOTHER'S OCCUPATION		BROTHERS' OCCUPATION		SISTERS' OCCUPATION	
MOTHER'S EDUCATION		FATHER'S EDUCATION		GRANDFATHER'S EDUCATION		GRANDMOTHER'S EDUCATION		BROTHERS' EDUCATION		SISTERS' EDUCATION	
MOTHER'S RELIGION		FATHER'S RELIGION		GRANDFATHER'S RELIGION		GRANDMOTHER'S RELIGION		BROTHERS' RELIGION		SISTERS' RELIGION	
MOTHER'S MARRIAGE		FATHER'S MARRIAGE		GRANDFATHER'S MARRIAGE		GRANDMOTHER'S MARRIAGE		BROTHERS' MARRIAGE		SISTERS' MARRIAGE	
MOTHER'S CHILDREN		FATHER'S CHILDREN		GRANDFATHER'S CHILDREN		GRANDMOTHER'S CHILDREN		BROTHERS' CHILDREN		SISTERS' CHILDREN	
MOTHER'S SIBLINGS		FATHER'S SIBLINGS		GRANDFATHER'S SIBLINGS		GRANDMOTHER'S SIBLINGS		BROTHERS' SIBLINGS		SISTERS' SIBLINGS	
MOTHER'S PARENTS		FATHER'S PARENTS		GRANDFATHER'S PARENTS		GRANDMOTHER'S PARENTS		BROTHERS' PARENTS		SISTERS' PARENTS	

CERTIFICATE OF DEATH

10080

Reg. Dist. No. 96

10099

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration			d. STREET ADDRESS 1119 Pine Heights		
3. NAME OF DECEASED (Type or print) First Warner B. Middle Dewling Last			4. DATE OF DEATH Month 9 Day 28 Year 19 58		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-96		9. AGE (In years last birthday) yrs. 62
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Candy Company	11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Benjamin F. Dewling			14. MOTHER'S MAIDEN NAME Lily Groves		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WV I	17. INFORMANT Address Not ascertainable Hospital Records, VAH, Perry Point, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Fibrosis of the myocardium due to degeneration DUE TO and replacement fibrosis, left ventricle Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease, severe DUE TO unknown (c)					INTERVAL BETWEEN ONSET AND DEATH unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from 9-27 to 9-28 , 1958 , and that death occurred at 10:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 9-29-58					
ACTUAL SIGNATURE S. P. LACERVA		PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-1-1958	22c. NAME OF CEMETERY OR CREMATORY Lorraine		22d. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Howard Strong, 3207 W. North Ave. Baltimore, Md.		24a. REC'D BY REGISTRAR DATE OCT 1 '58		24b. REGISTRAR'S SIGNATURE Charles S. Kraw	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Summary

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

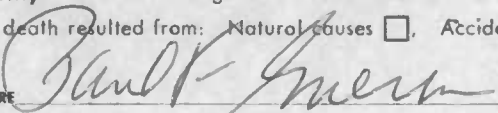
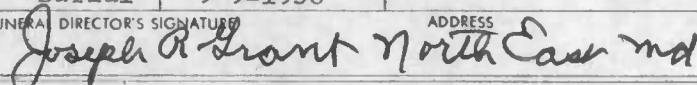
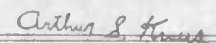
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10081

Reg. Dist. No.

10100

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rd		c. LENGTH OF STAY IN 1b 18 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rd	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS R.D. 2	
3. NAME OF DECEASED (Type or print) First Middle Last Betty M. Dunn			4. DATE OF DEATH Month Day Year 9 3 19 58		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-5, 1929		9. AGE (In years last birthday) 29 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New York	
13. FATHER'S NAME Orley Bennett			14. MOTHER'S MAIDEN NAME Etta Jones		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Ethel Petteys Wilton N.Y.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Craniocerebral Injury. 983X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Struck with blunt instrument.			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9/3 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	
				20f. (City or town) (County) (State) North East Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE 		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/4/58	
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-9-1958		22c. NAME OF CEMETERY OR CREMATORY Warrensburg, Warren Co., N.Y.	
23. FUNERAL DIRECTOR'S SIGNATURE 		ADDRESS North East Md		24a. REC'D BY REGISTRAR DATE SEP 8 '58	
				24b. REGISTRAR'S SIGNATURE 	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10101

Items 8,9 Film 234 10-6-58 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Cecil

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

North East R.D. 18 months

c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Cecil

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

North East R.D.

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

d. STREET ADDRESS

R. D. 2

e. IS RESIDENCE
ON A FARM?
YES ☐ NO ☐3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

Joanne

Dunn

4. DATE
OF
DEATH

Month

Day

Year

9

3

19 58

5. SEX

female

6. COLOR OR RACE

white

7. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

B. DATE OF BIRTH

June 26, 1957

9. AGE (In years
last birthday)

1

yrs.

IF UNDER 1 YEAR

Months Days

IF UNDER 24 HRS.

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10b. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Md

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Harry B. Dunn Jr

14. MOTHER'S MAIDEN NAME

Betty Bennett

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)

-

16. SOCIAL SECURITY NO.

-

17. INFORMANT

Address

Ethel Petteys Wilton N.Y.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

983x

Craniocerebral Injury.

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

INTERVAL BETWEEN
ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY
PERFORMED?
YES ☒ NO ☐20a. EXTERNAL CAUSE WAS
PRIMARY ☒ or CONTRIBUTING ☐
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

Struck with blunt instrument.

20c. TIME OF INJURY

Month, Day, Year

Hour

m. a.

9/3

1958

20d. INJURY OCCURRED

While
at work ☐Not while
at work ☒20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

Home

20f. (City or town)

North East

(County)

Cecil

(State)

Md.

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined monner ☐ACTUAL
SIGNATURE

Paul F. Guerin

M.D.

CHIEF MEDICAL EXAMINER ☐ASSISTANT MEDICAL EXAMINER ☒DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED

9/4/58

EXAMINER'S
NAME (Type)

Paul F. Guerin, M.D.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

9-9-1958

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

Warrensburg, Warren Co., Md N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

Joseph R Grant North East Md

24a. REC'D BY REGISTRAR

DATE SEP 8 '58

24b. REGISTRAR'S SIGNATURE

Arthur S. Hines

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		AGE 45		SEX Male		RACE White	
RESIDENCE 123 Main St, Baltimore, Md		OCCUPATION Teacher		EDUCATION High School		MARRIAGE Married	
DATE OF DEATH 10/15/1918		PLACE OF DEATH Home		CAUSE OF DEATH Pneumonia		MANNER OF DEATH Natural	
SIGNATURE OF EXAMINER [Signature]		DATE 10/16/1918		PLACE Baltimore, Md		OFFICE [Signature]	
FAMILY HISTORY None		SOCIAL HISTORY None		HISTORICAL None		PHYSICAL None	
LABORATORY None		RADIOLOGICAL None		PATHOLOGICAL None		TOXICOLOGICAL None	
POST-MORTEM None		OTHER None		REMARKS None		SIGNATURE OF DECEASED None	

10102

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.				c. LENGTH OF STAY IN 1b 29yrs.9mo.28days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilksburg 75X-3 ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1033 Wallace Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> unknown	
3. NAME OF DECEASED (Type or print)		First JOSEPH Middle L. Last ESCHER		4. DATE OF DEATH		Month September Day 4 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 25, 1891		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Steel Company		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Phillip Escher				14. MOTHER'S MAIDEN NAME Katherine Kenny			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) WW I		17. INFORMANT unknown		Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH immediate	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 6 , 19 28 , to September 4 , 19 58 , and that death occurred at 1:50 a.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 9-4-58 ACTUAL SIGNATURE S. P. LACERVA M.D. Director, Professional Services PHYSICIAN'S NAME (Type) S. P. LACERVA, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Sept. 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery		22d. LOCATION (City, town, or county) (State) Wilksburg, Allegheny Co. Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. Cook Inc. 1217 St. Paul Street, Baltimore, Md.				24a. REC'D BY REGISTRAR SEP 8 '58		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Department of Health. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10103

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 90

10084

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point	c. LENGTH OF STAY IN 1b Less than 24 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace 1224.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS Chapel Road	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E. Last FLETCHER		4. DATE OF DEATH Month September Day 16 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-26-95
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY unknown	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Columbus Fletcher		14. MOTHER'S MAIDEN NAME Julia Kate Troutwine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial fibrosis, severe 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (c), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Arteriosclerosis generalized severe			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. DODSON		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. C. DODSON		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-17-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/20/58	
22c. NAME OF CEMETERY OR CREMATORY Grove Presbyterian Church Yard		22d. LOCATION (City, town, or county) (State) Aberdeen, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John G. Tarring, Aberdeen, Maryland		24a. REC'D BY REGISTRAR DATE SEP 23 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

John G. Tarring

10085

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) Maryland Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 30yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Louis Richard Hartmann		4. DATE OF DEATH Month Day Year September 6 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1881
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Fireworks	
11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? Germany <input checked="" type="checkbox"/>	
13. FATHER'S NAME Gothard Hartmann		14. MOTHER'S MAIDEN NAME Fredrica Bach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 216-07-1827	
17. INFORMANT Mrs. Lucy Hartmann, 131 Maffitt St. Elkton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage - Sept 1 - 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug 25 1958 to Sept 6 1958 that I last saw the deceased alive on Sept 6 1958, and that death occurred at 8:30 P. M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED 135 W. Main St. Elkton, Md. 9/6/58	
ACTUAL SIGNATURE Oneford H. Sprackey M.D.		PHYSICIAN'S NAME (Type) Ralph E. Hicks	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/9/58	
22c. NAME OF CEMETERY OR CREMATORY Immaculate Conception		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		24a. REC'D BY REGISTRAR DATE SEP 15 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN DOE		2. SEX MALE		3. AGE 45		4. DATE OF BIRTH 1930-01-15		5. PLACE OF BIRTH NEW YORK, N.Y.	
6. OCCUPATION ENGINEER		7. MARITAL STATUS MARRIED		8. DATE OF MARRIAGE 1955-06-10		9. NAME OF SPOUSE JANE DOE		10. PLACE OF MARRIAGE NEW YORK, N.Y.	
11. CAUSE OF DEATH HEART DISEASE		12. MANNER OF DEATH NATURAL		13. DATE OF DEATH 1975-03-20		14. PLACE OF DEATH HOME		15. SIGNATURE OF DECEASED [Signature]	
16. SIGNATURE OF WITNESS [Signature]		17. SIGNATURE OF PHYSICIAN [Signature]		18. SIGNATURE OF CLERK [Signature]		19. SIGNATURE OF REGISTRAR [Signature]		20. SIGNATURE OF JUDGE [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10086

10104

1. PLACE OF DEATH o. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Haines Avenue</i>	
3. NAME OF DECEASED (Type or print) <i>John C. Hindman</i>		4. DATE OF DEATH <i>Sept. 10 1958</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 7, 1893</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Secretary</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Municipal</i>	
11. BIRTHPLACE (State or foreign country) <i>Rising Sun</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>	
13. FATHER'S NAME <i>John C. Hindman</i>		14. MOTHER'S MAIDEN NAME <i>Mary Harand</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>212-03-3476</i>	
17. INFORMANT <i>Mrs. John C. Hindman</i>		Address <i>Rising Sun, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Alfredus Sarcoma of</i> <i>152.7</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Left ilium.</i> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>6-1</i> 19 <i>58</i> to <i>9-10</i> 19 <i>58</i> , that I last saw the deceased alive on <i>9-10</i> 19 <i>58</i> , and that death occurred at <i>8:00</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Rising Sun, Md.</i> DATE SIGNED <i>9-10-58</i> ACTUAL SIGNATURE <i>R C Dodson</i> M.D. PHYSICIAN'S NAME (Type) <i>RC DODSON MD</i> <i>RISING SUN MD</i>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/13/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Brookview</i>	22d. LOCATION (City, town, or county) (State) <i>Rising Sun, Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M. Reed</i> ADDRESS <i>Rising Sun, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>SEP 15 '58</i>	24b. REGISTRAR'S SIGNATURE <i>Charles L. Kraus</i>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1934

第 2 章

23

1998

122

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal and in any event within 72 hours after death.

VS. A15ME
5M 2/57

STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10087

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick town		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fredericktown	
c. LENGTH OF STAY IN 1b 2 weeks		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Thirlun Eugene Hines		4. DATE OF DEATH Month 9 Day 5 Year 19 58	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-24-58
9. AGE (In years last birthday) yrs. 12		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rodney William Hines		14. MOTHER'S MAIDEN NAME Agnus Delores Williamson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Rodney W. Hines, Fredericktown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 763.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED	
EXAMINER'S NAME (Type) R. C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		9-5-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 4, 1958	
22c. NAME OF CEMETERY OR CREMATORY Cecil Am.		22d. LOCATION (City, town, or county) (State) Cecilton Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Feller		24a. REC'D BY REGISTRAR DATE SEP 9 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Haus			

2065215XV6

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
10086
Item 9 Film 6233 9-15-58 at
CERTIFICATE OF DEATH

10088

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Ft. Detm.</i>		c. LENGTH OF STAY IN 1b <i>10 min</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Warwick.</i>	
f. STREET ADDRESS <i>1</i>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Florence</i> Middle <i>Hollingsworth</i> Last <i>Hollingsworth</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>8</i> Year <i>1958</i>	
5. SEX <i>female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 14, 1900</i>
9. AGE (In years last birthday) <i>57 5/8</i> yrs.		10. IF UNDER 1 YEAR: Months <i>5</i> Days <i>14</i> Hours <i>14</i> Min. <i>14</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Hsuf.</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Warwick, Maryland.</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Theodore Lambert</i>		14. MOTHER'S MAIDEN NAME <i>Laura Veal</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Arthur Hollingsworth-Warrick, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Failure event Fib.</i> <i>420.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Heart Disease</i> DUE TO (c) <i>2 hours</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept 5</i> , 1958, to <i>Sept 8</i> , 1958, that I last saw the deceased alive on <i>Sept 8</i> , 1958, and that death occurred at <i>10:30</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wallace Obenshain</i> M.D.		ADDRESS (Street, city or town, state) <i>Cecil, Md.</i> DATE SIGNED <i>8 Sept 58</i>	
PHYSICIAN'S NAME (Type) <i>Wallace Obenshain, MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/13/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Bohemia Manor Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Bohemia Manor Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw. R. Bell</i> ADDRESS <i>Wilm. Del.</i>		24a. RECEIVED BY REGISTRAR <i>SEP 10 58</i> DATE	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10087

CERTIFICATE OF DEATH

10089

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Md.				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Ida R Huston				4. DATE OF DEATH Sept. 23 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1873	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North East, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Stephen J. Crouch				14. MOTHER'S MAIDEN NAME Rachel Lake			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. None		17. INFORMANT H. Clifford Huston Address North East, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion with Myocardial Infarction DUE TO (b) Hypertensive Cardiovascular Renal Disease DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 4 days 12 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 21 Sept 1958, to 23 Sept 1958, that I last saw the deceased alive on 22 Sept 1958, and that death occurred at 3:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Klaus H. Huckner M.D. North East, Md. 23 Sept 58 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) Klaus H. Huckner, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/58		22c. NAME OF CEMETERY OR CREMATORY North East Methodist Cemetery, North East, Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Grant ADDRESS North East, Maryland.				24a. REC'D BY REGISTRAR DATE SEP 29 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10090

10106

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Tiogo	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Earlville		c. LENGTH OF STAY IN 1b Visiting	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Liberty Township		75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pleasure Shores		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) Colby K Kline		4. DATE OF DEATH 9 27 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-28-1936
9. AGE (In years last birthday) 22 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Chester, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lewis C. Kline		14. MOTHER'S MAIDEN NAME Elizabeth Ponte fract	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes no 10/2/54		16. SOCIAL SECURITY NO. 68-30-3427	
17. INFORMANT R.W. Rorthwell. Chester, Pa.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Swimming in Elk River	
20c. TIME OF INJURY Month, Day, Year Hour 1:15 P.M. 927-58		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> of work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Elk River		20f. (City or town) (County) (State) Earlville Cecil Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		DATE SIGNED 9-28-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-1-58	
22c. NAME OF CEMETERY OR CREMATORY Salem Cem.		22d. LOCATION (City, town, or county) (State) Liberty Township Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks, Elkton, Md.		24a. REC'D BY REGISTRAR DATE OCT 6 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

10106

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10106

1. Name of deceased: _____

2. Sex: ☐ Male ☐ Female

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Usual residence: _____

7. Date of death: _____

8. Time of death: _____

9. Place of death: _____

10. Cause of death: _____

11. Manner of death: _____

12. Signature of medical examiner: _____

13. Signature of physician: _____

14. Signature of coroner: _____

15. Signature of registrar: _____

16. Signature of funeral director: _____

17. Signature of next of kin: _____

18. Signature of police officer: _____

19. Signature of other: _____

20. Signature of other: _____

21. Signature of other: _____

22. Signature of other: _____

23. Signature of other: _____

24. Signature of other: _____

25. Signature of other: _____

26. Signature of other: _____

27. Signature of other: _____

28. Signature of other: _____

29. Signature of other: _____

30. Signature of other: _____

31. Signature of other: _____

32. Signature of other: _____

33. Signature of other: _____

34. Signature of other: _____

35. Signature of other: _____

36. Signature of other: _____

37. Signature of other: _____

38. Signature of other: _____

39. Signature of other: _____

40. Signature of other: _____

41. Signature of other: _____

42. Signature of other: _____

43. Signature of other: _____

44. Signature of other: _____

45. Signature of other: _____

46. Signature of other: _____

47. Signature of other: _____

48. Signature of other: _____

49. Signature of other: _____

50. Signature of other: _____

51. Signature of other: _____

52. Signature of other: _____

53. Signature of other: _____

54. Signature of other: _____

55. Signature of other: _____

56. Signature of other: _____

57. Signature of other: _____

58. Signature of other: _____

59. Signature of other: _____

60. Signature of other: _____

61. Signature of other: _____

62. Signature of other: _____

63. Signature of other: _____

64. Signature of other: _____

65. Signature of other: _____

66. Signature of other: _____

67. Signature of other: _____

68. Signature of other: _____

69. Signature of other: _____

70. Signature of other: _____

71. Signature of other: _____

72. Signature of other: _____

73. Signature of other: _____

74. Signature of other: _____

75. Signature of other: _____

76. Signature of other: _____

77. Signature of other: _____

78. Signature of other: _____

79. Signature of other: _____

80. Signature of other: _____

81. Signature of other: _____

82. Signature of other: _____

83. Signature of other: _____

84. Signature of other: _____

85. Signature of other: _____

86. Signature of other: _____

87. Signature of other: _____

88. Signature of other: _____

89. Signature of other: _____

90. Signature of other: _____

91. Signature of other: _____

92. Signature of other: _____

93. Signature of other: _____

94. Signature of other: _____

95. Signature of other: _____

96. Signature of other: _____

97. Signature of other: _____

98. Signature of other: _____

99. Signature of other: _____

100. Signature of other: _____

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10107

10091

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pa. b. COUNTY Delaware	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hacks Point		c. LENGTH OF STAY IN lb 6 mo. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Drexel Hill 75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hacks Point		d. STREET ADDRESS 56 Revere Road Appart 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hulton First Middle Last McKeowan		4. DATE OF DEATH Month 9 Day 16 Year 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-29 - 1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman		10b. KIND OF BUSINESS OR INDUSTRY Paints Dupont	11. BIRTHPLACE (State or foreign country) Coatsville, Pa.
13. FATHER'S NAME William J. McKeowan		14. MOTHER'S MAIDEN NAME Alice Hulton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 164-05-8419	17. INFORMANT Harriet McKeowan, Address Drexel Hill Pa. 56 Revere Rd.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 9-16-58	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 9-16-58	22c. NAME OF CEMETERY OR CREMATORY West Chester, Chester Co. Penna.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE Peppin Funeral Home Donald M. Ree Elkton, Md		24a. REC'D BY REGISTRAR DATE SEP 17 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Knead

10001

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
RECORDING

REGISTERED
MEDICAL EXAMINER
THOMAS

1. Name of Deceased: WILLIAM
2. Date of Death: 1944
3. Place of Death: Home
4. Cause of Death: Heart Disease
5. Manner of Death: Natural
6. Signature of Medical Examiner: THOMAS
7. Date of Examination: 1944

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <i>Cherry Street</i>	
3. NAME OF DECEASED (Type or print) <i>Eugenia</i> First Middle Last <i>McVey</i>		4. DATE OF DEATH Month <i>Sept</i> Day <i>19</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/12/1882</i>
9. AGE (In years last birthday) <i>76</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>George Campbell</i>		14. MOTHER'S MAIDEN NAME <i>Ida Whitelock</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Stanley McVey, Rising Sun, Md</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>174X carcinoma of Uterus</i> DUE TO (b) <i>metastasized into colon</i> DUE TO (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7-10</i> 1957, to <i>9-19</i> 1958, that I last saw the deceased alive on <i>9-19</i> 1958, and that death occurred at <i>8:00</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. C. Dodson</i> M.D.		ADDRESS (Street, city or town, state) <i>Rising Sun Md</i> DATE SIGNED <i>9-20-58</i>	
PHYSICIAN'S NAME (Type) <i>R. C. DODSON</i>		<i>RISING SUN MD</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9/22/58</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Rosebank</i>	22d. LOCATION (City, town, or county) (State) <i>Calvert, Cecil. Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M Reed, Rising Sun, Md</i> ADDRESS		24a. REC'D BY REGISTRAR <i>SEP 23 '58</i> DATE	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all tags, papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 96

10093

10109

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. LENGTH OF STAY IN 1b 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Colora	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle E. Last MC VEY				4. DATE OF DEATH Month September Day 9 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-6-94	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 64 Days 64 Hours 64 Min. 64		IF UNDER 24 HRS. Months 64 Days 64 Hours 64 Min. 64			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter (Retired)				10b. KIND OF BUSINESS OR INDUSTRY New Jersey		11. BIRTHPLACE (State or foreign country) USA	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME George W. Mc Vey				14. MOTHER'S MAIDEN NAME Matilda Oestroich			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW I		17. INFORMANT Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyopneumothorax right DUE TO 162.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumectomy right lung 7-23-58 DUE TO (c) Anaplastic carcinoma of the right bronchus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized INTERVAL BETWEEN ONSET AND DEATH 10-15 days unknown							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from August 14 , 19 58 , to September 9 , 19 58 , and that death occurred at 8:35 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 9-10-58 ACTUAL SIGNATURE S. P. LACERVA M.D. PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services							
22a. BURIAL, CREMATION, REMOVAL (Specify) 9/10/58		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Brookview		22d. LOCATION (City, town, or county) (State) Rising Sun, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE SEP 16 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Klaus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1999

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10088

CERTIFICATE OF DEATH

10094

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>North East RURAL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSP</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Robert Davis MEADOWS</u>		4. DATE OF DEATH Month Day Year <u>Sept 11 1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 11 1938</u>
9. AGE (In years last birthday) yrs. <u>6</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>6</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>ELKTON</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Clarence Meadows</u>		14. MOTHER'S MAIDEN NAME <u>Mary Anderson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs Viola Anderson</u>		Address <u>Elkton Md Rt 1 Box 224</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pulmonary Atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Premature Infant - 33 wks. gestation</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs. 10 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>— 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>11 Sept. 1958</u> to <u>11 Sept. 1958</u> , that I last saw the deceased alive on <u>11 Sept. 1958</u> , and that death occurred at <u>9:15 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Klaus H. Huchner</u> M.D.		ADDRESS (Street, city or town, state) <u>No. 46 E. 1. Rd.</u> DATE SIGNED <u>11 Sept '58</u>	
PHYSICIAN'S NAME (Type) <u>Klaus H. Huchner M.D.</u>		<u>A</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept 12, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Boulders Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton R. D Cecil Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph A Grant</u> ADDRESS <u>North East 2nd</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

CERTIFICATE OF DEATH

10088

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. MARITAL STATUS		8. COLOR	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. SIGNATURE OF PHYSICIAN		15. SIGNATURE OF REGISTRAR		16. SIGNATURE OF WITNESSES	
17. PLACE OF INTERMENT		18. NAME OF INTERMENT PLACE		19. DATE OF INTERMENT		20. SIGNATURE OF INTERMENT OFFICIAL		21. SIGNATURE OF REGISTRAR		22. SIGNATURE OF WITNESSES		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF DECEASED	

Certificate of Death

This certificate is to be filled out by the physician or other qualified person who has attended the deceased or who has been informed of the cause of death. It is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10095

10089

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Delaware b. COUNTY New Castle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Newark			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Haven Nursing Home				d. STREET ADDRESS Elkton Road			
3. NAME OF DECEASED (Type or print) First Middle Last Alice Rebecca Meredith				4. DATE OF DEATH Month Day Year Sept. 5, 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 9, 1871	
9. AGE (In years day birthday) yrs. 86		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Delaware				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Franklin Eastburn				14. MOTHER'S MAIDEN NAME Mary Ellen Ruth			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Beulah E. Lewis		Address Elkton Rd., Newark, Del. RD# 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis general DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 2 weeks 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic interstitial nephritis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 5, 1957 , to 9/5/1958 , 19____, that I last saw the deceased alive on 9/4/58 , 19____, and that death occurred at 4:30 M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Wallace M. Johnson M.D. 257 E. Main Newark, Delaware							
ACTUAL SIGNATURE Wallace M. Johnson				PHYSICIAN'S NAME (Type) Wallace M. Johnson M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 8, 1958		22c. NAME OF CEMETERY OR CREMATORY White Clay Creek		22d. LOCATION (City, town, or county) (State) Newark, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE R.T. Jones				ADDRESS Newark, Del.		24a. REC'D BY REGISTRAR DATE SEP 9 '58	
						24b. REGISTRAR'S SIGNATURE Arthur L. House	

— — —

23

2007

О. С. Г.

10-522, 2, 3-65

July 2001

conditions of labor?

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific information required.

1

INSTRUCTIONS

1 hours after death. The law requires that the death certificate be executed within 72 hours after death. After this time, the certificate may be executed by the funeral director, the third copy of this certificate should be detached for use as a burial transit permit.

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the certificate may be executed by the funeral director, the third copy of this certificate should be detached for use as a burial transit permit.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the certificate may be executed by the funeral director, the third copy of this certificate should be detached for use as a burial transit permit.

VS AISC 1-53 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10096

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY Cecil MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural TOWN Port Deposit, Rural HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Cecil CITY (If outside corporate limits, write RURAL and give nearest town) Chesapeake TOWN Chesapeake OR City STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Mamie Vogue Moore		4. DATE OF DEATH (Month) (Day) (Year) 9 16 58	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, Married	8. DATE OF BIRTH May 16, 1895
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE last birthday 63 yrs.
11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Joseph Lloyd		14. MOTHER'S MAIDEN NAME Susan Lloyd	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) No		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Mrs Cyrus Burlin, Port Deposit, Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Massive Coronary Thrombosis ANTECEDENT CAUSE(S) DUE TO (B) Chronic Myocarditis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			24 hours
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 9-13 , 19 58 , to 9-16 , 19 58 , that I last saw the deceased alive on 9-15 , 19 58 , and that death occurred at 2:15 P.M. from the causes end on the date stated above.			
SIGNATURE Arthur S. Krause		ADDRESS (Street, city, town, state) Perryville, Md.	
DATE SEP 22 '58		25. FUNERAL DIRECTOR'S SIGNATURE See Patterson	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. REC'D BY REGISTRAR SEP 22 '58	
DATE		25. FUNERAL DIRECTOR'S SIGNATURE See Patterson	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Reg. No. 10

1910

1. NAME OF DECEASED OR DECEASING

Geoff. Md.

Chesapeake St. City

2. PLACE OF DEATH

Geoff.

Port Deposit, Md.

3. SEX

Male

Female

Male

4. DATE OF DEATH

18

88

5. RACE

White

Married

May 10, 1888

6. AGE

22

7. OCCUPATION

Own home

Wife

8. NAME OF PHYSICIAN

Lloyd

Queen

Lloyd

9. NAME OF FUNERAL HOME

Mrs. Cyrus Berlin, Port Deposit, Md.

10. MEDICAL EXAMINATION

11. CAUSE OF DEATH

12. PLACE OF BURIAL

13. NAME OF MINISTER

14. NAME OF CHURCH

15. NAME OF CEMETERY

16. NAME OF INTERVIEWER

17. NAME OF WITNESS

18. NAME OF SIGNER

19. NAME OF SIGNER

20. NAME OF SIGNER

21. NAME OF SIGNER

22. NAME OF SIGNER

23. NAME OF SIGNER

24. NAME OF SIGNER

25. NAME OF SIGNER

26. NAME OF SIGNER

27. NAME OF SIGNER

28. NAME OF SIGNER

29. NAME OF SIGNER

30. NAME OF SIGNER

31. NAME OF SIGNER

32. NAME OF SIGNER

33. NAME OF SIGNER

34. NAME OF SIGNER

35. NAME OF SIGNER

36. NAME OF SIGNER

37. NAME OF SIGNER

38. NAME OF SIGNER

39. NAME OF SIGNER

40. NAME OF SIGNER

41. NAME OF SIGNER

42. NAME OF SIGNER

43. NAME OF SIGNER

44. NAME OF SIGNER

45. NAME OF SIGNER

46. NAME OF SIGNER

47. NAME OF SIGNER

48. NAME OF SIGNER

49. NAME OF SIGNER

50. NAME OF SIGNER

51. NAME OF SIGNER

52. NAME OF SIGNER

53. NAME OF SIGNER

54. NAME OF SIGNER

55. NAME OF SIGNER

56. NAME OF SIGNER

57. NAME OF SIGNER

58. NAME OF SIGNER

59. NAME OF SIGNER

60. NAME OF SIGNER

61. NAME OF SIGNER

62. NAME OF SIGNER

63. NAME OF SIGNER

64. NAME OF SIGNER

65. NAME OF SIGNER

66. NAME OF SIGNER

67. NAME OF SIGNER

68. NAME OF SIGNER

69. NAME OF SIGNER

70. NAME OF SIGNER

71. NAME OF SIGNER

72. NAME OF SIGNER

73. NAME OF SIGNER

74. NAME OF SIGNER

75. NAME OF SIGNER

76. NAME OF SIGNER

77. NAME OF SIGNER

78. NAME OF SIGNER

79. NAME OF SIGNER

80. NAME OF SIGNER

81. NAME OF SIGNER

82. NAME OF SIGNER

83. NAME OF SIGNER

84. NAME OF SIGNER

85. NAME OF SIGNER

86. NAME OF SIGNER

87. NAME OF SIGNER

88. NAME OF SIGNER

89. NAME OF SIGNER

90. NAME OF SIGNER

91. NAME OF SIGNER

92. NAME OF SIGNER

93. NAME OF SIGNER

94. NAME OF SIGNER

95. NAME OF SIGNER

96. NAME OF SIGNER

97. NAME OF SIGNER

98. NAME OF SIGNER

99. NAME OF SIGNER

100. NAME OF SIGNER

101. NAME OF SIGNER

102. NAME OF SIGNER

103. NAME OF SIGNER

104. NAME OF SIGNER

105. NAME OF SIGNER

106. NAME OF SIGNER

107. NAME OF SIGNER

108. NAME OF SIGNER

109. NAME OF SIGNER

110. NAME OF SIGNER

111. NAME OF SIGNER

112. NAME OF SIGNER

113. NAME OF SIGNER

114. NAME OF SIGNER

115. NAME OF SIGNER

116. NAME OF SIGNER

117. NAME OF SIGNER

118. NAME OF SIGNER

119. NAME OF SIGNER

120. NAME OF SIGNER

121. NAME OF SIGNER

122. NAME OF SIGNER

123. NAME OF SIGNER

124. NAME OF SIGNER

125. NAME OF SIGNER

126. NAME OF SIGNER

127. NAME OF SIGNER

128. NAME OF SIGNER

129. NAME OF SIGNER

130. NAME OF SIGNER

131. NAME OF SIGNER

132. NAME OF SIGNER

133. NAME OF SIGNER

134. NAME OF SIGNER

135. NAME OF SIGNER

136. NAME OF SIGNER

137. NAME OF SIGNER

138. NAME OF SIGNER

139. NAME OF SIGNER

140. NAME OF SIGNER

141. NAME OF SIGNER

142. NAME OF SIGNER

143. NAME OF SIGNER

144. NAME OF SIGNER

145. NAME OF SIGNER

146. NAME OF SIGNER

147. NAME OF SIGNER

148. NAME OF SIGNER

149. NAME OF SIGNER

150. NAME OF SIGNER

151. NAME OF SIGNER

152. NAME OF SIGNER

153. NAME OF SIGNER

154. NAME OF SIGNER

155. NAME OF SIGNER

156. NAME OF SIGNER

157. NAME OF SIGNER

158. NAME OF SIGNER

159. NAME OF SIGNER

160. NAME OF SIGNER

161. NAME OF SIGNER

162. NAME OF SIGNER

163. NAME OF SIGNER

164. NAME OF SIGNER

165. NAME OF SIGNER

166. NAME OF SIGNER

167. NAME OF SIGNER

168. NAME OF SIGNER

169. NAME OF SIGNER

170. NAME OF SIGNER

171. NAME OF SIGNER

172. NAME OF SIGNER

173. NAME OF SIGNER

174. NAME OF SIGNER

175. NAME OF SIGNER

176. NAME OF SIGNER

177. NAME OF SIGNER

178. NAME OF SIGNER

179. NAME OF SIGNER

180. NAME OF SIGNER

181. NAME OF SIGNER

182. NAME OF SIGNER

183. NAME OF SIGNER

184. NAME OF SIGNER

185. NAME OF SIGNER

186. NAME OF SIGNER

187. NAME OF SIGNER

188. NAME OF SIGNER

189. NAME OF SIGNER

190. NAME OF SIGNER

191. NAME OF SIGNER

192. NAME OF SIGNER

193. NAME OF SIGNER

194. NAME OF SIGNER

195. NAME OF SIGNER

196. NAME OF SIGNER

197. NAME OF SIGNER

198. NAME OF SIGNER

199. NAME OF SIGNER

200. NAME OF SIGNER

201. NAME OF SIGNER

202. NAME OF SIGNER

203. NAME OF SIGNER

204. NAME OF SIGNER

205. NAME OF SIGNER

206. NAME OF SIGNER

207. NAME OF SIGNER

208. NAME OF SIGNER

209. NAME OF SIGNER

210. NAME OF SIGNER

211. NAME OF SIGNER

212. NAME OF SIGNER

213. NAME OF SIGNER

214. NAME OF SIGNER

215. NAME OF SIGNER

216. NAME OF SIGNER

217. NAME OF SIGNER

218. NAME OF SIGNER

219. NAME OF SIGNER

220. NAME OF SIGNER

221. NAME OF SIGNER

222. NAME OF SIGNER

223. NAME OF SIGNER

224. NAME OF SIGNER

225. NAME OF SIGNER

226. NAME OF SIGNER

227. NAME OF SIGNER

228. NAME OF SIGNER

229. NAME OF SIGNER

230. NAME OF SIGNER

231. NAME OF SIGNER

232. NAME OF SIGNER

233. NAME OF SIGNER

234. NAME OF SIGNER

235. NAME OF SIGNER

236. NAME OF SIGNER

237. NAME OF SIGNER

238. NAME OF SIGNER

239. NAME OF SIGNER

240. NAME OF SIGNER

241. NAME OF SIGNER

242. NAME OF SIGNER

243. NAME OF SIGNER

244. NAME OF SIGNER

245. NAME OF SIGNER

246. NAME OF SIGNER

247. NAME OF SIGNER

248. NAME OF SIGNER

249. NAME OF SIGNER

250. NAME OF SIGNER

251. NAME OF SIGNER

252. NAME OF SIGNER

253. NAME OF SIGNER

254. NAME OF SIGNER

255. NAME OF SIGNER

256. NAME OF SIGNER

257. NAME OF SIGNER

258. NAME OF SIGNER

259. NAME OF SIGNER

260. NAME OF SIGNER

261. NAME OF SIGNER

CERTIFICATE OF DEATH

10090

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>21 Elkton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>KANESSA</u> Middle <u>LOUISE</u> Last <u>NEWTON</u>		4. DATE OF DEATH Month <u>9</u> Day <u>3</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-1-58</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>	IF UNDER 24 HRS. Months <u>2</u> Days <u>2</u> Hours <u>2</u> Min. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME <u>Wesley Newton</u>		14. MOTHER'S MAIDEN NAME <u>Jane Schneiders</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Wesley Newton</u>		Address <u>235 W. Main St. Elkton</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>773.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute heart failure</u> DUE TO (c) <u>Premature</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 hours</u> <u>2 days</u> <u>2 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>9-1</u> , 19 <u>58</u> , to <u>9-3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-3</u> , 19 <u>58</u> , and that death occurred at <u>4:19</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>154 W. MAIN</u> DATE SIGNED <u>9-3-58</u>			
ACTUAL SIGNATURE <u>Peter J. Stavrakis</u> M.D.		PHYSICIAN'S NAME (Type) <u>PETER STAVRAKIS M.D.</u> <u>ELKTON Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph E. Nicks</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 5 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2065201XVI

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES H. HARRIS		SEX Male	AGE 68
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH Jan. 15, 1891	
OCCUPATION Retired		MARITAL STATUS Married	
PLACE OF DEATH Baltimore, Md.		DATE OF DEATH Jan. 15, 1959	
TIME OF DEATH 10:30 A.M.		CAUSE OF DEATH Myocardial Infarction	
PLACE OF INTERMENT St. Mary's Cemetery		DATE OF INTERMENT Jan. 17, 1959	
NAME OF FUNERAL HOME Harris Funeral Home		NAME OF PHYSICIAN Dr. J. H. Smith	
NAME OF CLERGYMAN Rev. J. H. Jones		NAME OF WITNESS Dr. J. H. Smith	
NAME OF REGISTRAR J. H. Smith		NAME OF CLERK J. H. Smith	



This certificate is to be filled out by the attending physician or the coroner, and is to be filed in the office of the Registrar of the State Department of Health. It is to be used for the purpose of determining the cause of death and for the purpose of determining the time and place of death. It is to be used for the purpose of determining the cause of death and for the purpose of determining the time and place of death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10098

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil 10091 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN 1b 2yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cherry Hill d. STREET ADDRESS X e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frederick Niemeier		4. DATE OF DEATH Month 9 Day 2 Year 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-4-1888
9. AGE (In years last birthday) 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer	11. BIRTHPLACE (State or foreign country) Wene, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Frederick Niemeier	
14. MOTHER'S MAIDEN NAME Elizabeth Beagle		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO. 222-09-4967		17. INFORMANT Frederick Niemeier Address Elkton, R.D.3 Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured abdominal aneurism 451X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. C. Addison M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Addison		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-3-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/6/58	22c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery	22d. LOCATION (City, town, or county) (State) Owego, New York
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE SEP 5 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Hanks

10034

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NOT STATE
NORTH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is divided into several horizontal sections with various labels and checkboxes.

NAME: [Blank]
AGE: [Blank]
SEX: [Blank]
RACE: [Blank]
DATE OF DEATH: [Blank]
PLACE OF DEATH: [Blank]
CAUSE OF DEATH: [Blank]
MANNER OF DEATH: [Blank]
SIGNATURE: [Blank]
DATE: [Blank]

MASSACHUSETTS DEPARTMENT OF HEALTH
BOSTON
OFFICE OF THE MEDICAL EXAMINER
100 STATE STREET
BOSTON, MASSACHUSETTS 02109

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED George		2. SEX Male		3. AGE 45	
4. OCCUPATION Police Detective		5. PLACE OF BIRTH Maryland		6. DATE OF BIRTH 1910	
7. PLACE OF DEATH Baltimore, Maryland		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. SIGNATURE OF MEDICAL EXAMINER [Signature]		11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF CORONER [Signature]	
13. DATE OF DEATH October 15, 1955		14. TIME OF DEATH 10:30 AM		15. PLACE OF INTERMENT [Blank]	
16. SIGNATURE OF MEDICAL EXAMINER [Signature]		17. SIGNATURE OF WITNESS [Signature]		18. SIGNATURE OF CORONER [Signature]	
19. DATE OF DEATH October 15, 1955		20. TIME OF DEATH 10:30 AM		21. PLACE OF INTERMENT [Blank]	
22. SIGNATURE OF MEDICAL EXAMINER [Signature]		23. SIGNATURE OF WITNESS [Signature]		24. SIGNATURE OF CORONER [Signature]	
25. DATE OF DEATH October 15, 1955		26. TIME OF DEATH 10:30 AM		27. PLACE OF INTERMENT [Blank]	
28. SIGNATURE OF MEDICAL EXAMINER [Signature]		29. SIGNATURE OF WITNESS [Signature]		30. SIGNATURE OF CORONER [Signature]	
31. DATE OF DEATH October 15, 1955		32. TIME OF DEATH 10:30 AM		33. PLACE OF INTERMENT [Blank]	
34. SIGNATURE OF MEDICAL EXAMINER [Signature]		35. SIGNATURE OF WITNESS [Signature]		36. SIGNATURE OF CORONER [Signature]	
37. DATE OF DEATH October 15, 1955		38. TIME OF DEATH 10:30 AM		39. PLACE OF INTERMENT [Blank]	
40. SIGNATURE OF MEDICAL EXAMINER [Signature]		41. SIGNATURE OF WITNESS [Signature]		42. SIGNATURE OF CORONER [Signature]	
43. DATE OF DEATH October 15, 1955		44. TIME OF DEATH 10:30 AM		45. PLACE OF INTERMENT [Blank]	
46. SIGNATURE OF MEDICAL EXAMINER [Signature]		47. SIGNATURE OF WITNESS [Signature]		48. SIGNATURE OF CORONER [Signature]	
49. DATE OF DEATH October 15, 1955		50. TIME OF DEATH 10:30 AM		51. PLACE OF INTERMENT [Blank]	
52. SIGNATURE OF MEDICAL EXAMINER [Signature]		53. SIGNATURE OF WITNESS [Signature]		54. SIGNATURE OF CORONER [Signature]	
55. DATE OF DEATH October 15, 1955		56. TIME OF DEATH 10:30 AM		57. PLACE OF INTERMENT [Blank]	
58. SIGNATURE OF MEDICAL EXAMINER [Signature]		59. SIGNATURE OF WITNESS [Signature]		60. SIGNATURE OF CORONER [Signature]	
61. DATE OF DEATH October 15, 1955		62. TIME OF DEATH 10:30 AM		63. PLACE OF INTERMENT [Blank]	
64. SIGNATURE OF MEDICAL EXAMINER [Signature]		65. SIGNATURE OF WITNESS [Signature]		66. SIGNATURE OF CORONER [Signature]	
67. DATE OF DEATH October 15, 1955		68. TIME OF DEATH 10:30 AM		69. PLACE OF INTERMENT [Blank]	
70. SIGNATURE OF MEDICAL EXAMINER [Signature]		71. SIGNATURE OF WITNESS [Signature]		72. SIGNATURE OF CORONER [Signature]	
73. DATE OF DEATH October 15, 1955		74. TIME OF DEATH 10:30 AM		75. PLACE OF INTERMENT [Blank]	
76. SIGNATURE OF MEDICAL EXAMINER [Signature]		77. SIGNATURE OF WITNESS [Signature]		78. SIGNATURE OF CORONER [Signature]	
79. DATE OF DEATH October 15, 1955		80. TIME OF DEATH 10:30 AM		81. PLACE OF INTERMENT [Blank]	
82. SIGNATURE OF MEDICAL EXAMINER [Signature]		83. SIGNATURE OF WITNESS [Signature]		84. SIGNATURE OF CORONER [Signature]	
85. DATE OF DEATH October 15, 1955		86. TIME OF DEATH 10:30 AM		87. PLACE OF INTERMENT [Blank]	
88. SIGNATURE OF MEDICAL EXAMINER [Signature]		89. SIGNATURE OF WITNESS [Signature]		90. SIGNATURE OF CORONER [Signature]	
91. DATE OF DEATH October 15, 1955		92. TIME OF DEATH 10:30 AM		93. PLACE OF INTERMENT [Blank]	
94. SIGNATURE OF MEDICAL EXAMINER [Signature]		95. SIGNATURE OF WITNESS [Signature]		96. SIGNATURE OF CORONER [Signature]	
97. DATE OF DEATH October 15, 1955		98. TIME OF DEATH 10:30 AM		99. PLACE OF INTERMENT [Blank]	
100. SIGNATURE OF MEDICAL EXAMINER [Signature]		101. SIGNATURE OF WITNESS [Signature]		102. SIGNATURE OF CORONER [Signature]	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10092

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21 Elkton	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital			d. STREET ADDRESS 200 E. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mollie Middle Pethersky Last			4. DATE OF DEATH Month 9 Day 22 Year 19 58		
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-1888	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Russia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Paul Samuel Ettnatz			14. MOTHER'S MAIDEN NAME Rosa		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Anna Pethersky, 200 E. Main St. Elkton Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Acute Coronary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Baltimore	(County) Md.	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9-22-58			
EXAMINER'S NAME (Type) R.C. Dodson					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal &		22b. DATE THEREOF 9-23-58		22c. NAME OF CEMETERY OR CREMATORY Rosedale	
22d. LOCATION (City, town, or county) Baltimore		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Jack Levin		ADDRESS 2100 Eutaw Place		24a. REC'D BY REGISTRAR SEP 24 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the State Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF
MARYLAND

DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY INTO STATE

DATE OF ENTRY INTO COUNTRY

DATE OF ENTRY INTO CITY

DATE OF ENTRY INTO DISTRICT

DATE OF ENTRY INTO WARD

DATE OF ENTRY INTO BLOCK

DATE OF ENTRY INTO HOUSE

DATE OF ENTRY INTO ROOM

DATE OF ENTRY INTO BED

DATE OF ENTRY INTO CHAIR

DATE OF ENTRY INTO TABLE

DATE OF ENTRY INTO CLOSET

DATE OF ENTRY INTO BATH

DATE OF ENTRY INTO KITCHEN

DATE OF ENTRY INTO LIVING ROOM

DATE OF ENTRY INTO BEDROOM

DATE OF ENTRY INTO PORCH

DATE OF ENTRY INTO GARAGE

DATE OF ENTRY INTO DRIVE

DATE OF ENTRY INTO YARD

DATE OF ENTRY INTO GARDEN

DATE OF ENTRY INTO POOL

DATE OF ENTRY INTO PATIO

DATE OF ENTRY INTO DECK

DATE OF ENTRY INTO PORCH

DATE OF ENTRY INTO GARAGE

DATE OF ENTRY INTO DRIVE

DATE OF ENTRY INTO YARD

DATE OF ENTRY INTO GARDEN

DATE OF ENTRY INTO POOL

DATE OF ENTRY INTO PATIO

DATE OF ENTRY INTO DECK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

10093

CERTIFICATE OF DEATH

Reg. Dist. No.

10101

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>	
c. LENGTH OF STAY IN <u>Life</u>		d. STREET ADDRESS <u>514 Bow st. Ext.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>V.</u> Last <u>Pierson</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>9</u> Year <u>1958</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 31, 1907</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Miller</u>		14. MOTHER'S MAIDEN NAME <u>Florence Stoddart</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-38-8434</u>	
17. INFORMANT <u>Wayne W. Pierson</u>		Address <u>Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> <u>196.9</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>anaplastic, bone</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>March 21, 1958</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 21, 1958</u> to <u>Sept 9, 1958</u> , that I last saw the deceased alive on <u>Sept 8, 1958</u> , and that death occurred at <u>5-20</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Elkton, Md.</u> DATE SIGNED <u>Sept. 9, 1958</u>	
ACTUAL SIGNATURE <u>Milford H. Sprecher</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Milford H. Sprecher</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Sept. 12, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home</u> ADDRESS <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 15 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10094

CERTIFICATE OF DEATH

Reg. Dist. No.

10102

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Elkton</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Warwick.</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Union Hospital</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First <i>Anne</i> Middle <i>He</i> Last <i>Ringgold</i>		4. DATE OF DEATH Month <i>Sept.</i> Day <i>6</i> Year <i>1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 21, 1957</i>
9. AGE (In years last birthday) <i>10</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>10</i> Days <i>10</i> Hours <i>10</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Elkton, Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>Elkton, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Ringgold</i>		14. MOTHER'S MAIDEN NAME <i>Bernice Jenkins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>none</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>John Ringgold- Warrick, Maryland</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Lobar pneumonia</i> <i>490X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>19</i> o. m. <i>19</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5 Sept</i> , 19 <i>58</i> , to <i>6 Sept</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>6 Sept</i> , 19 <i>58</i> , and that death occurred at <i>8:45</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Wallace Oberlin</i>		ADDRESS (Street, city or town, state) <i>Cecilton Md</i>	
PHYSICIAN'S NAME (Type) <i>Arthur S. Throck</i>		DATE SIGNED <i>6 Sept 58</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9/10/58</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Methodist Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Cecilton, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Sh. R. Bell</i>		ADDRESS <i>909 Poplar St., Wil</i>	
24a. REC'D BY REGISTRAR <i>SEP 10 58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Throck</i>	

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10103

10095

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>R.D. # 2 North East</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Union Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Alvin Chester Russell</u>		4. DATE OF DEATH Month Day Year <u>Sept. 15, 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 17, 1878</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Roads</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Mathew Russell</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Smith</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT Address <u>Mrs. Richard Shumway North East, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left Cerebral Thrombosis</u> DUE TO (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>?</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Date nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>— 19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>	
21. I certify that I attended the deceased from <u>13 Sept</u> , 19 <u>58</u> , to <u>15 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>15 Sept</u> , 19 <u>58</u> , and that death occurred at <u>1:35 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Klaus H. Huchner</u> M.D.		ADDRESS (Street, city or town, state) <u>No. 4 East Rd</u> DATE SIGNED <u>15 Sept '58</u>	
PHYSICIAN'S NAME (Type) <u>Klaus H. Huchner M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/18/1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Bay View Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Bay View, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Pippin Funeral Home</u> <u>Donald M. Pippin</u> <u>Elkton, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 17 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. PLACE OF BIRTH		6. PLACE OF DEATH	
JAMES H. HARRIS		Male		45		White		Maryland		Maryland	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. PLACE OF INTERMENT		12. NAME OF CLERGYMAN	
April 15, 1918		10:30 A.M.		Heart Disease		Natural		Catholic Cemetery		Rev. J. J. Harris	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF CLERGYMAN		16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF JURY	
19. NAME OF PHYSICIAN		20. NAME OF CLERGYMAN		21. NAME OF REGISTRAR		22. NAME OF JURY		23. NAME OF WITNESSES		24. NAME OF CLERGYMAN	
Dr. J. J. Harris		Rev. J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris	
25. NAME OF CLERGYMAN		26. NAME OF REGISTRAR		27. NAME OF JURY		28. NAME OF WITNESSES		29. NAME OF CLERGYMAN		30. NAME OF REGISTRAR	
Rev. J. J. Harris		J. J. Harris		J. J. Harris		J. J. Harris		Rev. J. J. Harris		J. J. Harris	

10112

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b all life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Elkton R.D.2	
3. NAME OF DECEASED (Type or print) Wilbur Emerson Shockley		4. DATE OF DEATH Month 9 Day 26 Year 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-28-24
9. AGE (In years last birthday) 33 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Geh Motors Auto Mfg.		10b. KIND OF BUSINESS OR INDUSTRY Newark, Del.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John P. Shockley		14. MOTHER'S MAIDEN NAME Gertrude Lane	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes W.W.2		16. SOCIAL SECURITY NO. 215-24-032	
17. INFORMANT John P. Shockley, Elkton, R.D.2. Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Drowned 850x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell off boat in Elk River Elkton	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Elkton R.D.		20f. (City or town) Elkton (County) Cecil (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		DATE SIGNED 9-30-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 1, 1958	
22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) Nr. Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		24a. REC'D BY REGISTRAR OCT 2 '58	
ADDRESS Elkton, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Finney	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF MASSACHUSETTS
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
1914

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar	
Date of Certificate		Time of Certificate		Place of Certificate	

10113

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Maryland		c. LENGTH OF STAY IN 1b 19 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Trench Last Trench		4. DATE OF DEATH Month 9 Day 7 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-18-81
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shoemaker (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Shoe Repair	
11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Trench		14. MOTHER'S MAIDEN NAME Helen McKinsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If year, month, or dates of service) unknown	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 153.8 IMMEDIATE CAUSE (a) Pulmonary edema and congestion, bilateral DUE TO (b) Hepato-renal syndrome DUE TO (c) Excision of rectum 9-5-58 for adenocarcinoma of large bowel widespread metastasis - locally		INTERVAL BETWEEN ONSET AND DEATH 38 hrs. unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis generalized moderate		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8-19- 1958 , to 9-7- 1958 , and that death occurred at 8:40A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 9-8-58			
ACTUAL SIGNATURE S. P. LACERVA M.D.		PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services	
22. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 9/10/58	22c. NAME OF CEMETERY OR CREMATORY Angel Hill	22d. LOCATION (City, town, or county) (State) Havre de Grace, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.		24a. REC'D BY REGISTRAR DATE SEP 10 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

10114

CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY b. STATE <div style="text-align: center; font-size: 1.2em;">Cecil MARYLAND District of Columbia</div>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE b. COUNTY <div style="text-align: center;">Washington 47X-3</div>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 17 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		d. STREET ADDRESS 4113 - 7th Street, N.W.	
3. NAME OF DECEASED (Type or print) First Middle Last JOHN W. WALKER		4. DATE OF DEATH Month Day Year September 28 19 58	
5. SEX x Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-26-05
9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dr. J. W. Walker		14. MOTHER'S MAIDEN NAME Elinor Curtis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW II		16. SOCIAL SECURITY NO. 040-05-2741	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia bilateral severe unresolved 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 3-5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized, moderate			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from September 11, 19 58, to September 28, 19 58, and that death occurred at 4:30 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE S. P. LACERVA		DATE SIGNED V.A. Hospital, Perry Point, Md. 9-29-58	
PHYSICIAN'S NAME (Type) S. P. LACERVA Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF 10/2/58	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Motens Funeral Home, 2718-12th St., N.E. Wash. D.C.		24a. REC'D BY REGISTRAR OCT 1 '58	24b. REGISTRAR'S SIGNATURE Charles E. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please ~~remove~~ carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1. *Examine the following text and identify the main topic and the author's purpose. Write a short paragraph summarizing the text.*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

STATE OF MARYLAND—BALTIMORE, 18										10107	
Items 5, 6 & 7, Film G234 10/9/58 fcy											
10096										Reg. Dist. No.	
1. PLACE OF DEATH a. COUNTY Cecil MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton					c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, Md.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hosp.					d. STREET ADDRESS RDA#1					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Howard F. Walls					4. DATE OF DEATH Month Day Year Sept 25 1958						
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 16, 1879		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired farmer					10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Kent Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Howard Walls					14. MOTHER'S MAIDEN NAME Rebecca Paschke						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] NONE					16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Thomas Duff. Earlsville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease. DUE TO (c) years. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senility										INTERVAL BETWEEN ONSET AND DEATH 7 min.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Sept 20, 1958, to Sept 25, 1958, that I last saw the deceased alive on Sept 25, 1958, and that death occurred at 12:30 M, from the causes and on the date stated above.											
ACTUAL SIGNATURE Wallace Oberchain M.D.					ADDRESS (Street, city or town, state) Cecilton, Maryland					DATE SIGNED 25 Sept 58	
PHYSICIAN'S NAME (Type)											
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF Sept. 28/58		22c. NAME OF CEMETERY OR CREMATORY Cecilton Cem.			22d. LOCATION (City, town, or county) (State) Cecilton Md.				
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Edward Pellow Millington Md.					24a. REC'D BY REGISTRAR DATE OCT 2 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus				

10115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun		c. LENGTH OF STAY IN 1b 7 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rising Sun	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 13 S. Walnut			d. STREET ADDRESS 13 South Walnut		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Richard	First	Middle H.	Last Wilson	4. DATE OF DEATH 9 Month 1 Day 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-22-1910	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Drugist		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Herman Richard Wilson			
14. MOTHER'S MAIDEN NAME Margaret L. Lynch		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 159-01-2459		17. INFORMANT Margaret L. Wilson, 2935 Gerritt St. Phil. Pa			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct & Aneurysm 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic Cardiovascular Disease DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Philadelphia, Pa.	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE William H. [Signature]		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Sept 1 1958	
EXAMINER'S NAME (Type) J. G. Carl Tyson		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF Sept 4/58		22c. NAME OF CEMETERY OR CREMATORY Philadelphia, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE J. G. Carl Tyson		ADDRESS Rising Sun		24a. REC'D BY REGISTRAR SEP 3 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. House	

NEW YORK STATE DEPARTMENT OF HEALTH - BALTHAMORE TO
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [Name] 2. SEX: [Male/Female] 3. AGE: [Age]

4. RACE: [Race] 5. BIRTH DATE: [Date] 6. BIRTH PLACE: [Place]

7. DECEASED DATE: [Date] 8. DECEASED PLACE: [Place]

9. DECEASED TIME: [Time] 10. DECEASED HOURS: [Hours]

11. DECEASED MINUTES: [Minutes] 12. DECEASED SECONDS: [Seconds]

13. DECEASED DAYS: [Days] 14. DECEASED MONTHS: [Months]

15. DECEASED YEARS: [Years] 16. DECEASED CENTURY: [Century]

17. DECEASED DECADES: [Decades] 18. DECEASED CENTURIES: [Centuries]

19. DECEASED MILLENNIA: [Millennia] 20. DECEASED EPOCHS: [Epochs]

21. DECEASED AGES: [Ages] 22. DECEASED PERIODS: [Periods]

23. DECEASED CYCLES: [Cycles] 24. DECEASED PHASES: [Phases]

25. DECEASED STAGES: [Stages] 26. DECEASED LEVELS: [Levels]

27. DECEASED DEGREES: [Degrees] 28. DECEASED DIRECTIONS: [Directions]

29. DECEASED POSITIONS: [Positions] 30. DECEASED LOCATIONS: [Locations]

31. DECEASED SITES: [Sites] 32. DECEASED AREAS: [Areas]

33. DECEASED ZONES: [Zones] 34. DECEASED REGIONS: [Regions]

35. DECEASED TERRITORIES: [Territories] 36. DECEASED DOMAINS: [Domains]

37. DECEASED REALMS: [Realms] 38. DECEASED KINGDOMS: [Kingdoms]

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10109

Reg. Dist. No.

10116

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Singerly		c. LENGTH OF STAY IN 1b all life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Singerley	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First George Middle W Last Woodrow			4. DATE OF DEATH Month 9 Day 29 Year 19 58		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-28-1874		9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab.		10b. KIND OF BUSINESS OR INDUSTRY General work		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Joseph S. Woodrow			14. MOTHER'S MAIDEN NAME No information		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Ruth Woodrow, Elkton Gen. Deliv. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Acute Coronary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE R. C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R. C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		9-30-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/2/58		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery	
				22d. LOCATION (City, town, or county) (State) Cherry Hill Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Tucker		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE OCT 3 '58	
				24b. REGISTRAR'S SIGNATURE Arthur A. Haines	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER - CERTIFICATE OF DEATH



Dec 11 1934

Dec 11 1934

Dec 11 1934

Dec 11 1934

Dec 11 1934

Dec 11 1934

Dec 11 1934

Dec 11 1934

X

Dec 11 1934

Dec 11 1934

Dec 11 1934